



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date

MAR - 4 2002

From

Thomas D. Roslewicz
Deputy Inspector General
for Audit Services

Subject

To

Review of Managed Care Additional Benefits at NYLCare Health Plans of the Southwest, Inc. for Calendar Year 2000 (A-06-00-00073)

Neil Donovan
Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

As part of self-initiated audits by the Office of Inspector General, we are alerting you to the issuance within 5 business days from the date of this memorandum of our final report entitled, "Review of Managed Care Additional Benefits at NYLCare Health Plans of the Southwest, Inc. for Calendar Year 2000." A copy of the report is attached. This report is one of a series of reports involving managed care additional benefits. We suggest that you share this report with components of the Centers for Medicare & Medicaid Services (CMS) involved in the Medicare managed care organization operations, particularly the Center for Health Plans and Policy.

The objective of our audit was to assess whether additional benefits proposed in NYLCare's Contract Year (CY) 2000 adjusted community rate proposal (ACRP) were available to Medicare beneficiaries at reasonable costs and as advertised, and that these benefits were both credible and properly valued.

Our review focused on NYLCare's prescription drug benefit. Our review found that, during 2000, NYLCare provided additional benefits as proposed in its CY 2000 ACRP and as advertised in its marketing brochures. We also found that NYLCare provided prescription drugs to Medicare enrollees at reduced rates by taking advantage of discounts negotiated with independent pharmacies that dispensed the prescription drugs.

However, our review disclosed problems with the prescription drug benefit component on NYLCare's CY 2000 ACRP that impacted both the Medicare beneficiaries enrolled in the plan, as well as NYLCare itself. The problems were as follows:

- In calculating the 1998 base year expenditures on the CY 2000 ACRP, NYLCare did not consider volume discounts received from drug manufacturers for prescription drugs purchased during 1998. Therefore, the 1998 base year costs for prescription drugs were overstated on the CY 2000 ACRP. NYLCare officials told us that they were unaware that the volume discounts were recorded in the financial records at Aetna U.S. Healthcare (Aetna), NYLCare's parent company.

- By not considering volume discounts when calculating prescription drug limits for its Medicare enrollees during 2000, NYLCare may have unnecessarily reduced the number of covered prescriptions available to the beneficiaries under their annual brand name drug limits. Consequently, the beneficiaries may not have received the full amount of the prescription drug benefit to which they were entitled, potentially paying up to \$4.0 million over the actual cost of their prescription drugs.
- During 2000, NYLCare expended more than the estimated prescription drug benefit projected in the CY 2000 ACRP resulting in a financial loss on NYLCare's 2000 prescription drug benefit. Failing to consider volume discounts and the projection methodologies used in preparing the ACRP may have contributed to this loss. We emphasize, however, that because the scope of our audit included only prescription drugs, this conclusion refers *only* to the prescription drug benefit. We did not audit the remaining Medicare benefits included in the CY 2000 ACRP and, therefore, made no conclusions about actual profit or loss on the entire package of Medicare benefits included in the ACRP.

While we recognized that NYLCare was no longer a participant in the Medicare+Choice program, we provided the results of our review to NYLCare and made the following recommendations:

- Should NYLCare decide to re-establish its Medicare managed care program sometime in the future, we encouraged the company to consider the results of this audit and ensure that all components of actual costs, including volume discounts, are accounted for in preparing the ACRP.
- We urged NYLCare to share our report with officials of NYLCare's parent company, Aetna. In turn, Aetna should ensure that all of its subsidiaries involved in the Medicare+Choice program are calculating their ACRPs accurately by including volume discounts in the base year calculations for prescription drug costs. They should also be reducing actual prescription drug costs by the amount of volume discounts received from prescription drug manufacturers.

Aetna responded to our report on behalf of the NYLCare plan. Aetna agreed that volume discounts should have been included in NYLCare's ACRP base year calculations for drug costs and assured us that all other Aetna-owned Medicare+Choice plans have calculated their ACRPs accordingly. However, Aetna disagreed with all other conclusions and recommendations we made. We have summarized Aetna's response in the body of the report, and the complete response is included as an Appendix. We modified our final report to incorporate Aetna's comments as appropriate. However, the Office of Inspector General maintains its original view on the other conclusions and all of the recommendations we made regarding this audit.

Page 3 – Neil Donovan

We would encourage CMS to consider clarifying its ACRP instructions to include language that requires Medicare+Choice organizations to include any reductions in cost, such as volume discounts, in the development of the adjusted community rate. This would enable actual costs to be reflected in the ACRP, as required by regulations.

Any questions or comments on any aspect of our report are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104, or Gordon L. Sato, Regional Inspector General for Audit Services, Region VI, at (214) 767-8414.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MANAGED CARE
ADDITIONAL BENEFITS AT NYLCARE
HEALTH PLANS OF THE SOUTHWEST,
INC. FOR CALENDAR YEAR 2000**



**JANET REHNQUIST
Inspector General**

**MARCH 2002
A-06-00-00073**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

MAR - 7 2002

Office of Audit Services
1100 Commerce, Room 6B6
Dallas, TX 75242

Ms. Celina Burns
General Manager, Medicare Division
Aetna U.S. Healthcare
2777 Stemmons Freeway, 3rd Floor
Dallas, Texas 75207

Dear Ms. Burns:

This final report provides the results of our review of additional benefits offered by NYLCare Health Plans of the Southwest, Inc. (NYLCare), in the Contract Year (CY) 2000 adjusted community rate proposal (ACRP). During 2000, NYLCare provided managed care services under a Medicare+Choice contract (Contract H-4507) to Medicare beneficiaries in north-central Texas. NYLCare discontinued providing Medicare managed care services in 2001.

The objective of our review was to assess whether:

- additional benefits proposed in NYLCare's CY 2000 ACRP were available to Medicare beneficiaries in accordance with NYLCare's marketing materials;
- additional benefits were credible; that is, the Medicare beneficiaries enrolled in the plan received value in excess of the copayments required to obtain the benefits;
- estimated costs in the ACRP for the additional benefits were reasonable when compared to the costs actually incurred; and
- additional benefits were properly valued.

Our review focused on NYLCare's prescription drug benefit. Our review found that, during 2000, NYLCare provided additional benefits as proposed in its CY 2000 ACRP and as advertised in its marketing brochures. We also found that NYLCare provided prescription drugs to Medicare enrollees at reduced rates by taking advantage of discounts negotiated with independent pharmacies that dispensed the prescription drugs.

However, our review disclosed problems with the prescription drug benefit component on NYLCare's CY 2000 ACRP that impacted both the Medicare beneficiaries enrolled in the plan, as well as NYLCare itself. The problems were as follows:

- In calculating the 1998 base year expenditures on the CY 2000 ACRP, NYLCare did not consider volume discounts received from drug manufacturers for prescription drugs purchased during 1998. Therefore, the 1998 base year costs for prescription drugs were overstated on the CY 2000 ACRP. NYLCare officials told us that they were unaware that

the volume discounts were recorded in the financial records at Aetna U.S. Healthcare (Aetna), NYLCare's parent company.

- By not considering volume discounts when calculating prescription drug limits for its Medicare enrollees during 2000, NYLCare may have unnecessarily reduced the number of covered prescriptions available to the beneficiaries under their annual brand name drug limits. Consequently, the beneficiaries may not have received the full amount of the prescription drug benefit to which they were entitled, potentially paying up to \$4.0 million over the actual cost of their prescription drugs.
- During 2000, NYLCare expended more than the estimated prescription drug benefit projected in the CY 2000 ACRP resulting in a financial loss on NYLCare's 2000 prescription drug benefit. Failing to consider volume discounts and the projection methodologies used in preparing the ACRP may have contributed to this loss. We emphasize, however, that because the scope of our audit included only prescription drugs, this conclusion refers *only* to the prescription drug benefit. We did not audit the remaining Medicare benefits included in the CY 2000 ACRP and, therefore, made no conclusions about actual profit or loss on the entire package of Medicare benefits included in the ACRP.

While we recognized that NYLCare was no longer a participant in the Medicare+Choice program, we nevertheless wanted to provide the results of our review to NYLCare and made the following recommendations:

- Should NYLCare decide to re-establish its Medicare managed care program sometime in the future, we encouraged the company to consider the results of this audit and ensure that all components of actual costs, including volume discounts, are accounted for in preparing the ACRP.
- We urged NYLCare to share our report with officials of NYLCare's parent company, Aetna. In turn, Aetna should ensure that all of its subsidiaries involved in the Medicare+Choice program are calculating their ACRPs accurately by including volume discounts in the base year calculations for prescription drug costs. They should also be reducing actual prescription drug costs by the amount of volume discounts received from prescription drug manufacturers.

Aetna responded to our draft report on behalf of the NYLCare plan. Aetna agreed that volume discounts should have been included in NYLCare's ACRP base year calculations for prescription drug costs and assured us that all other Aetna-owned Medicare+Choice plans have calculated their ACRPs accordingly. However, Aetna disagreed with all other conclusions and recommendations we made. Aetna's complete response to our draft report is included as an Appendix to this report.

We modified our final report to incorporate Aetna’s comments as appropriate. However, the Office of Inspector General (OIG) maintains its original view on the conclusions and the recommendations we made regarding this audit. When all adjustments related to a Medicare+Choice organization (M+CO) are not recorded, the potential impact of each individual ACR proposal cannot be accurately assessed to ensure that the Medicare managed care program is operating effectively. As a result, the medical needs of Medicare beneficiaries may be hampered if M+COs are not properly recording all costs. This may also result in the Centers for Medicare & Medicaid Services (CMS), Congress, and policymakers not being fully informed about the actual financial needs of M+COs.

INTRODUCTION

BACKGROUND

The Medicare ACRP process is designed for M+COs to present to CMS their estimates of the funds needed to cover the medical and administrative costs of providing the Medicare package of covered services to any enrolled Medicare beneficiary. The ACRP process also includes providing estimates of additional benefits (e.g., prescription drugs and eyeglasses) the M+CO plans to offer its Medicare enrollees.

An M+CO must complete a separate ACR proposal for each coordinated care or private fee-for-service plan offered to Medicare beneficiaries. Through the ACR proposals, M+COs present to CMS an initial rate that represents the “commercial premium” the organization would charge its non-Medicare enrollees for services included in the managed care plan. This initial rate is then adjusted by various factors described in the regulations, including the relative costs to Medicare beneficiaries, to establish an appropriate payment rate that reflects the characteristics of the Medicare population. The accuracy of the specific parts of the ACR proposal is critical to ensuring that M+COs receive appropriate payments that are consistent with their commercial premiums. The ACR proposal also provides a mechanism for the M+CO to provide additional benefits to Medicare beneficiaries or to credit the program if payments received exceed the properly adjusted commercial rate.

Additional benefits are health care services not covered by Medicare and reductions in premiums or cost sharing for Medicare-covered services. Additional benefits are specified by the M+COs and are offered uniformly to all Medicare beneficiaries at no additional premiums. Those benefits must be at least equal in value to the adjusted excess amount calculated in the ACRP. An excess amount is created when the average payment rate (estimated monthly capitation payment received from CMS) exceeds the adjusted community rate (as reduced by the actuarial value of coinsurance, copayments, and deductibles under Parts A and B of Medicare).

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our review was to assess whether:

- additional benefits proposed in NYLCare's CY 2000 ACRP were available to Medicare beneficiaries in accordance with NYLCare's marketing materials;
- additional benefits were credible; that is, the Medicare beneficiaries enrolled in the plan received value in excess of the copayments required to obtain the benefits;
- estimated costs in the ACRP for the additional benefits were reasonable when compared to costs actually incurred; and
- additional benefits offered were properly valued.

NYLCare submitted CY 2000 ACRPs for three levels of Medicare coverage: Medicare 5, Medicare 10, and Medicare Premier. Because NYLCare's Medicare membership was enrolled almost exclusively in the Medicare 5 option, we concentrated our audit efforts on this option. Consequently, for this report, all references to NYLCare's additional benefits will include data and analyses of only the Medicare 5 option.

Prescription drugs comprised about 98 percent of NYLCare's base year costs for additional benefits; therefore, we focused our in-depth analysis on prescription drugs. To accomplish our objective, we reviewed:

- NYLCare's ACRP submission and compared it with NYLCare's marketing materials to ensure consistency of the dollar limits and copayments.
- NYLCare's 1998 base year financial data, which was used to project the CY 2000 ACRP.
- The 2000 actual costs for prescription drugs and compared these costs with the proposed amount for prescription drugs in the ACRP. We selected two judgmental samples of prescription drug claims for review. One sample (29 claims) was used to verify the Medicare beneficiaries' enrollment in the plan and whether NYLCare had correctly counted the prescription drug costs against the beneficiaries' annual brand name prescription drug limits. For the second sample (46 claims), we: (1) traced the claims to source invoice documents, (2) determined the actual prices NYLCare paid for the prescription drugs, and (3) compared these prices with average wholesale prices published in the *Red Book*, a prescription drug pricing publication used by the pharmaceutical industry.
- Five pharmacy contracts to determine the pricing agreements between NYLCare and the pharmacies for brand name and generic prescription drugs.

- NYLCare’s 2000 Medication Formulary Guide of “preferred” generic and brand name medications and made a judgment about the reasonableness of prescription drugs excluded from coverage by NYLCare.

NYLCare provided us the total amount of volume discounts associated with the prescription drugs purchased during 1998 and 2000 by Medicare beneficiaries enrolled in the plan. These volume discounts represent a partial refund from prescription drug manufacturers for the large volume of prescription drugs purchased. Because NYLCare obtained the volume discount amounts from its parent company, Aetna, we did not verify the amounts, but instead relied on the accuracy of the amounts as reported to us by NYLCare.

We did not audit NYLCare’s ACRP or its financial records, nor did we conduct a review of the plan’s internal controls, because these steps were not considered necessary to achieve our objectives. Our review was conducted in accordance with generally accepted government auditing standards. Field work was performed at NYLCare and at the Dallas field office in Dallas, Texas.

RESULTS OF REVIEW

Our review found that, during 2000, NYLCare provided additional benefits as proposed in its CY 2000 ACRP and as advertised in its marketing brochures. We also found that NYLCare provided prescription drugs to Medicare enrollees at reduced rates by taking advantage of discounts negotiated with independent pharmacies that dispensed the prescription drugs. However, our review disclosed problems with the prescription drug benefit component on NYLCare’s CY 2000 ACRP that impacted both the Medicare beneficiaries enrolled in the plan, as well as NYLCare itself. The problems were as follows:

- In calculating the 1998 base year expenditures on the CY 2000 ACRP, NYLCare did not consider volume discounts received from drug manufacturers for prescription drugs purchased during 1998. Therefore, the 1998 base year costs for prescription drugs were overstated on the CY 2000 ACRP. NYLCare officials told us that they were unaware that the volume discounts were recorded in the financial records at Aetna, NYLCare’s parent company.
- By not considering volume discounts when calculating prescription drug limits for its Medicare enrollees during 2000, NYLCare may have unnecessarily reduced the number of covered prescriptions available to the beneficiaries under their annual brand name drug limits. Consequently, the beneficiaries may not have received the full amount of the prescription drug benefit to which they were entitled, potentially paying up to \$4.0 million over the actual cost of their prescription drugs.

- During 2000, NYLCare expended more than the estimated prescription drug benefit projected in the CY 2000 ACRP, resulting in a financial loss on NYLCare's 2000 prescription drug benefit. Failing to consider volume discounts and the projection methodologies used in preparing the ACRP may have contributed to this loss.

***Verification of NYLCare's
Additional Benefits as
Submitted in CY 2000 ACRP***

NYLCare's additional benefits, submitted with its CY 2000 ACRP, included outpatient prescription drugs, routine physical examinations, vision, dental, hearing services, and health/wellness education. NYLCare's Benefit Information Form, submitted with its ACRP, showed additional benefits at the levels and copayments as advertised in its marketing materials provided to current and potential Medicare enrollees. Because prescription drugs comprised about 98 percent of NYLCare's base year costs for additional benefits, we focused our in-depth analysis on prescription drugs. NYLCare's prescription drug benefit included an annual limit per enrollee of \$1,000 for brand name prescription drugs and no limit on the amount for generic prescription drugs. Listed below is a schedule of the copayments required:

Type of Prescription drug	Retail Pharmacy (30-day supply)	Mail Order Pharmacy (90-day supply)
Brand Name	\$20	\$40
Generic	\$10	\$20
Brand Name Non-Formulary	\$35	\$70

***Review of ACRP Base Year
and Actual Costs for
Additional Benefits
Disclosed Errors With
Negative Impacts***

We reviewed NYLCare's 1998 financial records and determined that the prescription drug cost centers included in the ACRP base year calculations were consistent with the 2000 prescription drug cost centers. We also reviewed NYLCare's 2000 actual costs to determine how they compared with NYLCare's projected ACRP amounts for prescription drugs.

Our review of NYLCare's financial records showed that, during 2000, NYLCare expended more than the estimated prescription drug benefit included in the ACRP. Our review also disclosed that, in preparing the additional benefits portion of its ACRP, NYLCare did not take into consideration volume discounts received from prescription drug manufacturers for prescription drugs purchased under the additional benefits option.

Excess Expenditures for Prescription Drugs During 2000

In executing the CY 2000 ACRP, NYLCare's 2000 actual expenditures for prescription drugs exceeded the ACRP projection. When preparing the ACRP, NYLCare underestimated the potential prescription drug costs. While we recognize that the prescription drug projection is only an estimate, based on actuarial trends, we believe that this underestimation contributed to the excess expenditures for prescription drugs.

Exclusion of Volume Discounts Received From Prescription Drug Manufacturers

Federal regulations (42 CFR 422.310(a)(5)) require that generally accepted accounting principles (GAAP) be followed in accumulating costs to develop the ACRP. Under GAAP, the costs of the prescription drugs would consist of expenses incurred by NYLCare for the prescription drugs, reduced by the corresponding revenues (volume discounts) received from prescription drug manufacturers for those prescription drugs. By excluding volume discounts from the prescription drug costs, NYLCare appeared to have violated GAAP.

NYLCare officials told us that, until we had questioned whether volume discounts were taken into consideration, they were unaware that the volume discounts were recorded in the financial records at Aetna, NYLCare's parent company. According to the NYLCare officials, the operating agreement between Aetna and NYLCare does not include passing volume discounts from the parent company to its subsidiary company.

At our request, NYLCare officials contacted Aetna to obtain the total amount of volume discounts attributable to NYLCare's prescription drug purchases during 1998 and 2000. The actual amounts reported to NYLCare by Aetna were \$743,170 and \$4,073,000, respectively. We have not audited these amounts, but instead are relying on the accuracy of the amounts as reported to us by NYLCare.

Impact of Excluding Volume Discounts During CY 1998

By excluding volume discounts from the 1998 base year calculations, NYLCare's ACRP overstated prescription drug costs by \$743,170. This overstatement of prescription drug costs contributed to an inaccurate ACR, resulting in less additional benefits for Medicare enrollees.

To quantify the effect of excluding the volume discounts from the base year costs, we reduced NYLCare's actual 1998 prescription drug costs by the volume discount amount and then recalculated NYLCare's ACRP. After trending the revised base year amounts to CY 2000, the modified ACRP showed that NYLCare potentially could have offered the Medicare beneficiaries another \$3.4 million in additional benefits or reduced premium/cost-sharing amounts (based on the actual enrollment levels).

Impact of Excluding Volume Discounts During CY 2000

We noted that, in accumulating prescription drug costs against each Medicare beneficiary's annual brand name prescription drug limit of \$1,000, NYLCare's prescription drug costs included discounts from independent pharmacies that dispensed the prescription drugs. These discounted costs were passed along to the Medicare beneficiaries.¹ However, because NYLCare failed to *also* pass along the volume discounts of \$4 million in computing the prescription drug costs, the plan potentially allowed the higher prescription drug costs to deplete each beneficiary's annual prescription drug limit at a faster rate. To illustrate this point, consider the following example for an individual beneficiary:

Brand Name Prescription Drug Purchases	Costs in Computing the Limit	Brand Name Prescription Drug Limit \$1,000	Discounted Cost*	Brand Name Prescription Drug Limit \$1,000
#1	\$100	\$900	\$87	\$913
#2	100	800	87	826
#3	100	700	87	739
#4	100	600	87	652
#5	100	500	87	565
#6	100	400	87	478
#7	100	300	87	391
#8	100	200	87	304
#9	100	100	87	217
#10	100	0	87	130
#11			87	43
#12			87	0

*Represents reduced prescription drug costs based on actual 2000 volume discounts of 13%

This example shows that, had the volume discounts been taken into consideration, the Medicare beneficiary potentially would have received additional prescription drugs. Instead, NYLCare charged the higher prescription drug costs against the beneficiary's annual brand name prescription drug limit, without first deducting the volume discounts. Consequently, the Medicare beneficiaries enrolled in NYLCare may not have received the full amount of the prescription drug benefit to which they were entitled, potentially paying up to \$4 million over the actual cost of their prescription drugs.

¹See "Comparison of NYLCare's Prescription Drug Costs With Pharmacy Contracts and Average Wholesale Prices" on page 9.

***Verification That NYLCare
Correctly Charged
Prescription Drugs
Against Beneficiaries’
Annual Prescription Drug
Limits***

volume discounts as noted above.

***Comparison of NYLCare’s
Prescription Drug Costs With
Pharmacy Contracts and
Average Wholesale Prices***

NYLCare had contracts with independent pharmacies that dispensed prescription drugs to NYLCare’s enrollees in accordance with prescriptions written by NYLCare’s medical providers. We reviewed NYLCare’s contracts with five pharmacies (four retail pharmacies and one nationwide mail order pharmacy) to determine the pricing agreements between NYLCare and the pharmacies for brand name and generic prescription drugs. All of the contracts included agreements that allowed NYLCare to purchase prescription drugs at discounted prices.²

To test these contract pricing agreements, we randomly selected 46 claims from NYLCare’s June 2000 data file of prescription drug claims that corresponded with the top brand name and generic prescription drugs listed in the 1998 edition of the *Red Book*. We traced the claims to source invoice documents. We then compared the prices NYLCare paid for the prescription drugs with the average wholesale prices for the same prescription drugs listed in the 2000 edition of the *Red Book*, taking into consideration the discounts listed in the pharmacy contracts. Our review showed that NYLCare paid prescription drug prices in accordance with the pricing agreements in the pharmacy contracts and comparable to *Red Book* prices.

***Analysis of NYLCare’s
2000 Medication
Formulary Guide***

We reviewed NYLCare’s 2000 “Medication Formulary Guide” that lists the “preferred” generic and brand name medications available through NYLCare’s prescription drug benefit plan. According to the formulary guide, NYLCare will cover brand name and generic prescription drugs approved by the Food and Drug Administration and selects prescription drugs based on their safety, effectiveness, and overall value. The formulary guide listed 497 brand name prescription drugs, along with their generic equivalents, and an additional 337 generic prescription drugs.

The guide also contains a formulary exclusions list of 160 medications that are not covered. For each excluded prescription drug, NYLCare also listed formulary alternatives, which are

²It is common practice in the pharmaceutical industry to quote prescription drug prices as a factor of average wholesale price (AWP); for example, AWP minus 18 percent. The AWP can be defined as an average of the prices charged by national prescription drug wholesalers for a given prescription drug. The prices are based on surveys of manufacturers, distributors, and other suppliers and are published in sources such as the *Red Book*, a prescription drug pricing publication used by the pharmaceutical industry. Actual prices paid by retailers may vary.

therapeutically equivalent prescription drugs listed on its formulary guide. NYLCare enrollees can obtain non-formulary brand name prescription drugs, but a higher copayment is required.

Based on our review, we believe that NYLCare's prescription drug formulary was reasonable.

CONCLUSION AND RECOMMENDATIONS

Our review found that, during 2000, NYLCare provided the additional benefits as proposed in its CY 2000 ACRP and as advertised in its marketing materials. We also found that NYLCare provided prescription drugs to Medicare enrollees at reduced rates by taking advantage of discounts negotiated with independent pharmacies that dispensed the prescription drugs.

However, our review disclosed problems with the prescription drug benefit component on NYLCare's CY 2000 ACRP that impacted both the Medicare beneficiaries enrolled in the plan, as well as NYLCare itself. The problems were as follows:

- In calculating the 1998 base year expenditures on the CY 2000 ACRP, NYLCare did not consider volume discounts received from drug manufacturers for prescription drugs purchased during 1998. Therefore, the 1998 base year costs for prescription drugs were overstated on the CY 2000 ACRP.
- By not considering volume discounts when calculating prescription drug limits for its Medicare enrollees during 2000, NYLCare may have unnecessarily reduced the number of covered prescriptions available to the beneficiaries under their annual brand name drug limits. Consequently, the beneficiaries may not have received the full amount of the prescription drug benefit to which they were entitled, potentially paying up to \$4.0 million over the actual cost of their prescription drugs.
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While we recognized that NYLCare was no longer a participant in the Medicare+Choice program, we nevertheless provided the results of our review to NYLCare and made the following recommendations:

- Should NYLCare decide to re-establish its Medicare managed care program sometime in the future, we encouraged the company to consider the results of this audit and ensure that all components of actual costs, including volume discounts, are accounted for in preparing the ACRP.
- We urged NYLCare to share our report with officials of NYLCare’s parent company, Aetna. In turn, Aetna should ensure that all of its subsidiaries involved in the Medicare+Choice program are calculating their ACRPs accurately by including volume discounts in the base year calculations for prescription drug costs. They should also be reducing actual prescription drug costs by the amount of volume discounts received from prescription drug manufacturers.

***Aetna’s Comments
On Behalf of NYLCare***

An official of Aetna U.S. Healthcare responded to our draft report on behalf of the NYLCare plan.

Aetna concurred with our conclusion that volume discounts should have been included in NYLCare’s base year calculations for prescription drug costs. The company assured us that all other Aetna-owned Medicare+Choice plans have calculated their ACRPs accordingly.

Aetna disagreed with all of the remaining conclusions and recommendations we made. We have summarized their objections below:

- 1) Aetna disagreed with our conclusion that NYLCare’s underestimation of potential prescription drug costs on its CY 2000 ACRP may have resulted from inadequate projection methodologies. Aetna maintains that NYLCare’s financial loss on its prescription drug benefit was the result of underestimated projections.
- 2) While Aetna agreed that volume discounts should have been included in the ACRP base year calculations, they disagreed with our conclusion that actual prescription drug costs should have been reduced by the amount of volume discounts when calculating Medicare beneficiaries’ annual maximum prescription drug benefits. Aetna gave several reasons for their position:
 - (a) NYLCare’s administration of the annual maximum prescription drug benefit calculation was fully consistent with the assumptions used to develop the 2000 annual maximum benefit. According to Aetna, NYLCare developed the annual maximum benefit based on its contracted rates with participating pharmacies, excluding volume discounts, and therefore, the beneficiaries received the benefit of the annual maximum that they, in fact, paid for.
 - (b) Aetna is not aware of any CMS directives or instructions that require health plans to reflect the value of volume discounts in actual prescription drug costs.

- (c) Aetna states that reflecting volume discounts in the annual maximum prescription drug benefit “inappropriately focuses on a single, line-item adjustment while neglecting to consider the potential impact of such adjustment on the development and pricing of the overall benefit.” Aetna maintains that considering volume discounts in this manner “would increase the costs incurred by health plans, which in turn could result in increased plan premiums, reduced plan benefits or further limits on annual benefit maximums...Members should receive the benefit of volume discounts because such discounts should be reflected in the ACR rate development process.”
 - (d) Volume discounts are invoiced and received from pharmaceutical manufacturers retrospectively. Therefore, the prescription drug costs cannot be reduced by the value of the volume discounts at the time the prescription drugs are purchased.
- 3) Aetna also disagreed with our conclusion that, as a result of the exclusion of volume discounts, the beneficiaries may have been overcharged for prescription drugs.

The full text of Aetna’s response can be found in the Appendix to this report. The OIG changed the report to reflect Aetna’s response regarding their projections.

<i>OIG’s Response</i>	We modified our final report to incorporate Aetna’s comments as appropriate. The OIG understands Aetna’s objection to reducing actual prescription drug costs by the actual amount of volume discounts that have not yet been received. However, we believe that Aetna could have provided an estimated reduction in prescription drug costs to NYLCCare based on the historical volume of discounts received. We also believe that not considering volume discounts in calculating actual prescription drug costs allowed Aetna to retain all of the volume discounts without providing any of the associated benefits to the Medicare beneficiaries. As a result, Medicare beneficiaries may have been overcharged for the brand name prescription drugs they purchased.
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While there is no CMS directive or ACRP instruction specifically requiring health plans to reflect volume discounts, instructions do require health plans to reflect the proper costs in developing their ACRs. The OIG maintains that the inclusion of volume discounts would be more reflective of proper costs. In addition, Aetna indicated in its comments that it concurs that it is appropriate to include volume discounts in the base year calculations for drug costs and that it had done so in its remaining Medicare+Choice plans.

The OIG agrees that the inclusion of volume discounts in developing the annual maximums may result in increased plan premiums. However, because the development of the 2000 ACR did not factor in any volume discounts, either in the base year or in the projections, then it could not be determined whether plan premiums would be impacted.

When all adjustments related to an M+CO are not recorded, the potential impact of each individual ACR proposal cannot be accurately assessed to ensure that the Medicare managed care program is operating effectively. As a result, the medical needs of Medicare beneficiaries may be hampered if M+COs are not properly recording all costs. This may also result in CMS, Congress, and policymakers not being fully informed about the actual financial needs of M+COs.

INSTRUCTIONS FOR AUDITEE RESPONSE

Final determinations as to actions to be taken on all matters reported will be made by the CMS action official identified below. We request that you respond to the recommendations in this report within 30 days from the date of this report to the CMS action official, presenting any comments or additional information that you believe may have a bearing on final determinations.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, OIG, Office of Audit Services reports are made available to the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR part 5.) As such, within 10 business days after the final report is issued, it will be posted on the world wide web at <http://oig/hhs.gov>.

Sincerely,



Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

CMS Action Official:

James F. Farris, MD
Regional Administrator
Centers for Medicare & Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202



2777 Stemmons Freeway
Suite 300
Dallas, TX 75207

Celina Burns
General Manager
214/200-8750

October 18, 2001

Mr. Gordon L. Sato
Regional Inspector General
for Audit Services
Department of Health & Human Services
Office of Audit Services
1100 Commerce, Room 6B6
Dallas, TX 75242

Dear Mr. Sato:

Re: Common Identification Number: A-06-00-00073

We are in receipt of your draft report entitled "Review of Managed Care Additional Benefits at NYLCare Health Plans of the Southwest, Inc., for Calendar Year 2000." The subject Medicare+Choice contract (Contract H-4507) was non-renewed at the end of the Y2000 contract period (December 31, 2000). This response is submitted on behalf of Aetna U.S. Healthcare Inc. as the prior parent company and administrator to the NYLCare Health Plans of the Southwest, Inc. (NYLCare 65 Medicare Plan). We appreciate the opportunity to review and comment on your draft report and will focus on the two recommendations you have made.

General Comments

First, we believe the four objectives stated on your review assessment have been satisfied. (p. 1)

Second, we concur with your review finding that "NYLCare was providing additional benefits as proposed in its Y2000 ACRP and as advertised in its marketing brochures." (p. 5)

Third, we concur with your review finding that "NYLCare also provided drugs to Medicare enrollees and reduced rates by taking advantage of discounts negotiated with independent pharmacies that dispensed the drugs." (p. 5)

Fourth, we concur that ACRP prescription drug projections were only an estimate and that these estimates "created a financial loss in NYLCare's 2000 prescription drug benefit." (pp. 2, 5)

Fifth, we concur with your finding that NYLCare's 1998 financial records and "prescription drug cost centers included in the ACRP base year calculation were consistent with the 2000 prescription drug cost centers" and that "NYLCare expended more than the estimated prescription drug benefit included in the ACRP." (p. 6)

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Sixth, except for the statement with respect to volume discounts, we concur with your finding and verification that NYLCare had correctly calculated the drug costs against the beneficiaries annual drug limits. (p. 8)

Seventh, we concur with your finding and review that "All of the contracts included agreements that allowed NYLCare to purchase drugs at discounted prices" and "that NYLCare paid drug prescription in accordance with the pricing agreements in the pharmacy contracts...." (pp. 8-9)

Finally, we concur with your analysis of the NYLCare 2000 Medication Formulary Guide that concluded that the "NYLCare prescription drug formulary was reasonable." (p. 9)

Comments to Recommendations

With respect to your first recommendation (p. 10) you have appropriately noted that NYLCare is no longer a participant in the Medicare+Choice program. As the prior parent company and administrator of the NYLCare 65 Medicare Plan, we would, as encouraged by your report, consider the results of this audit should Aetna U.S. Healthcare or any of its affiliates re-enter the M+C program. We have no current plans to re-establish a program in the Contract H-4507 service area. Please see our further response to your second recommendation relative to the calculation and inclusion of volume discounts in preparing ACRPs. While we concur with this first conclusion, we do not, however, concur with your "observations about inaccurate methodologies used to project costs." Your report appropriately notes that prescription drug projections are only estimates that are based upon actuarial trends. While the actuarial methodology used was appropriate, these projections ultimately proved to be underestimated, and they "created a financial loss on NYLCare's 2000 prescription drug benefit."

With respect to your second recommendation (p. 10) we have shared the report as requested with appropriate staff at Aetna that have responsibility in connection with Medicare+Choice ACRP filings. We have determined that the currently remaining Medicare+Choice plans have calculated their ACRPs by including volume discounts in the base year calculations for drug costs.

While we concur that it is appropriate to include volume discounts in the base year calculations for drug costs, we disagree with your recommendation to reduce actual prescription drug costs by the amount of volume discounts when calculating members' annual maximum prescription drug benefit. We further disagree with your statement that Medicare members may have been "overcharged" because volume discounts were not reflected in such calculation. There are several reasons why we do not believe there is any support for this recommendation.

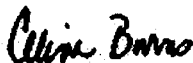
As a preliminary matter, we do not agree that members were in any way "overcharged" in connection with NYLCare's 2000 prescription drug benefit. It is important to note that NYLCare's administration of the annual maximum benefit calculation was fully consistent with the assumptions used to develop the 2000 annual maximum benefit. As discussed in greater detail below, NYLCare developed the annual maximum benefit based on its contracted rates with participating pharmacies excluding any volume discounts received from manufacturers. In this respect, members received the benefit of the annual maximum that they in fact paid for. Furthermore, as the OIG correctly notes in its draft report, NYLCare experienced "a financial loss on [its] 2000 prescription drug benefit" (p. 2). This financial loss was the result of premium rates that were inadequate to cover the actual costs of the benefit provided.

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Second, we are not aware of any CMS directive, ACRP instruction or provision of the Uniform ACRP Examination Program that requires health plans to reflect the value of volume discounts in the manner suggested. Third, the recommendation to reflect volume discounts in the calculation of the member's annual maximum benefit inappropriately focuses on a single, line-item adjustment while neglecting to consider the potential impact of such adjustment on the development and pricing of the overall benefit. Properly considered, the OIG's recommendation could increase members' premiums or reduce the level of benefits that health plans can offer. In this particular case, NYLCare appropriately determined the annual maximum benefit level and the plan's pricing based on the reimbursement rates negotiated with participating pharmacies. The inclusion of volume discounts in developing the annual maximum benefit would increase the costs incurred by health plans, which in turn could result in increased plan premiums, reduced plan benefits or further limits on annual benefit maximums. It is important to note that the exclusion of volume discounts from the calculation of the annual maximum benefit should not prevent members from realizing the benefits of the reduction in pharmacy costs that results from volume discounts received by the plan. Members should receive the benefit of volume discounts because such discounts should be reflected in the ACR rate development process.

Finally, volume discounts are invoiced and received by the Plan from pharmaceutical manufacturers retrospectively. Thus, the value of volume discounts is not known at point of sale when the cost accumulated against the member's annual maximum benefit is calculated.

Sincerely yours,



Celina Burns
General Manager
Aetna U.S. Healthcare

c: Ms. A. Raylene Mason, Senior Auditor